California Primary Care ASSOCIATION

June 7, 2016

Carole D'Elia
Executive Director
Little Hoover Commission
925 L Street, Suite 805
Sacramento, CA 95914

Re: Community Clinic and Health Center Participation in the Mental Health Services Act

Dear Ms. D'Elia,

The California Primary Care Association (CPCA) appreciates the opportunity to comment on the Little Hoover Commission's report on the progress of the Mental Health Services Act (MHSA). Since being approved by voters in 2004, the MHSA has undoubtedly expanded access to community-based mental health treatment and other rehabilitative services. Yet, as the Commission notes in *Promises Still to Keep: A Decade of the Mental Health Services Act*, a lack of effective oversight and outcome data truncates our ability to measure progress, reduces confidence in MHSA's potential, and makes the Act vulnerable to amendments that move resources out of these important behavioral health programs. It is vitally important to resolve the Act's imperfections in order to realize its full potential as a catalyst for innovation and to ensure that we are reaching the maximum number of clients suffering from mental illness.

CPCA is a non-profit organization representing more than 1,150 California community clinics and health centers (CCHCs) and nearly 6 million CCHC patients, a majority of whom come from racially and ethnically diverse communities. Over 85% of CPCA's member health centers have successfully integrated primary and mental health care services in culturally and linguistically appropriate manners in order to treat co-occurring physical and mental health conditions. CCHCs universally screen primary care patients with behavioral assessments to ensure mental health conditions are captured and addressed early, prior to becoming severe. CCHCs' long history of providing integrated behavioral health services to the Medi-Cal population is a valuable resource that can be leveraged to promote the MHSA's goal to provide innovative, community-based interventions to prevent and treat mental illness. Additionally, as trusted community representatives, CCHCs play a significant role as ambassadors for stigma reduction by promoting accessible, non-threatening, non-judgmental treatment.

Many CCHCs partner with their counties on projects funded by MHSA. The resources that CCHCs receive from both Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) sources provide an array of services that otherwise would not be available to Medi-Cal enrollees. For example, LifeLong Medical Care in Alameda County provides mobile mental health outreach, case management and psychiatry services for homeless seniors with serious mental illness (SMI). With their MHSA grant, CommuniCare Health Center in Yolo County offers full-scope mental health, medical, case-management, outreach, and assistance with SSI enrollment for Latino/Hispanic underserved community members.

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Community-based providers like CCHCs are critical partners in the provision of SMI services, as patients are able to access behavioral health services at their point of primary care, reducing stigma, ensuring coordination, and delivering a holistic approach to health and wellness.

While there are numerous examples throughout the state of partnerships that positively impact the lives of shared county/FQHC patients, examples also abound of counties who are unwilling to partner with community-based providers and other organizations to create a whole-person care delivery system. Medi-Cal enrollees with severe mental illness (SMI) are served by more than just a county mental health system. We contend that a stronger monitoring and oversight system, coupled with intensive outcomes evaluation will demonstrate the need for counties to partner with community-based providers in order to meet the needs of patients. To be most effective, MHSA-funded resources need to follow the patient to the community, and not require the patient to go to where the resources are, to the county. CCHCs need to be included as partners in the mental health care continuum in order to support the goals of MHSA.

The following are our considerations and recommendations that would strengthen the MHSA to demonstrate intended outcomes, thus assuring Californians that their investment in the mental health delivery system yields intended returns.

1) Local MHSA resources are apportioned at the discretion of the counties with no requirement to partner with other organizations who share the same patients, resulting in disjointed systems of care.
The full spectrum of mental health care is not exclusively provided by county mental health delivery systems. Counties and their Mental Health Plans are the primary funders for behavioral health services provided to patients with SMI and these efforts are largely supported by MHSA funds[1]. But there does exist a full continuum of care outside of the county system for patients with mild to moderate and severe mental illness which is largely supported by non-profit federally qualified health centers and billed to Medi-Cal. In fact, research increasingly points to primary care as a critical point for patients that might not otherwise seek assistance for their behavioral health needs in other settings due to stigma. A recent report by the UCLA Center for Health Policy cites that more than 70% of behavioral health conditions are diagnosed and treated within the primary care setting, underscoring just how critical the role of primary care is in linking patients to care for their behavioral health conditions.[2]

CCHCs have a long history of serving underserved and low-income populations through integrated care models that focus on prevention and team-based care in a trusted environment that reflects the unique needs of their communities. More than 70% of CCHC patients are people of color, and by mission CCHCs focus on providing culturally and linguistically diverse services to low income and non-English speaking communities. Additionally, 76% of CCHC patients are at or below 200% of the Federal Poverty Level (FPL) and nearly 40% identify a language other than English as their primary language. They are a trusted community provider, and serve patients with mental illness who will not seek care at the county or other settings due to language and cultural barriers and stigma about the county system. CCHCs are often the best first responders to divert complications of serious mental illness, and can be key partners

[1] As referenced by District Chief of Los Angeles County's MHSA program, Debbie Innes-Gomber, "MHSA funds act as both the primary funding source for programs, as well as the match for Medi-Cal services that fund recovery-oriented mental health services and supports." Promise still to keep, page 11

[2] [1] Pourat, N et. al. (Jan. 2015). "One-Stop Shopping: Efforts to Integrate Physical and Behavioral Health Care in Five California Community Health Centers." Available at http://healthpolicy.ucla.edu/publications/Documents/PDF/2015/integrationbrief-jan2015.pdf

in meeting the needs of communities of color who are otherwise untouched and underserved by the county system.

There has always been a need for behavioral health services, but the need was exacerbated with the implementation of the ACA. Today more than ever before health centers are witnessing that an overwhelming percentage of their patients require behavioral health support and there are simply not sufficient resources to deliver the necessary primary and preventive services. Especially given the diverse communities that are served by CCHCs, these patients are falling through the cracks of a county-led behavioral health system that does not have the cultural and language resources to adequately serve these populations. It is a travesty that CCHC patients do not have adequate access to MHSA resources which would help ameliorate the challenges in providing all that is necessary to help their patient's live fully productive lives.

Despite the enormous role that CCHCs play in providing care to diverse communities with mild, moderate, and severe mental illness, in many cases counties do not coordinate care with non-county providers as no requirement exists to mandate partnerships, and local MHSA resources are not shared with the non-county delivery system. Yet, part of MHSA's charge is to provide for the prevention and early intervention of mild to moderate conditions before they become severe – in other words, before a patient has to access the county system. CCHCs focus on early interventions could be far better leveraged by the MHSA-funded PEI programs, which would ultimately serve the larger MHSA more effectively as mental health crises would be diverted before they become severe. In writing *Promises Still to Keep*, the Little Hoover Commission overlooked the opportunity to examine how effectively / or ineffectively MHSA funds are being used by counties to reach Californians with mental illness who are served outside of the county system. ***We recommend that the Little Hoover Commission revisit the MHSA study, and evaluate how effectively funds are being used to support the integration of services at CCHCs and other non-county primary care providers to meet the behavioral health care needs of non-english speaking communities and people of color.*** It is our contention that tax payer resources could be better spent if they leveraged they community health center network in California, which has built a robust behavioral health delivery system for over 6 million Californians.

2) There still exists a need to thoughtfully reexamine a structured mechanism for transparently reporting financial and outcome data.

As explained in *Promises Still to Keep*, the MHSA Oversight and Accountability Commission (MHSOAC) is charged with fiscal oversight and accountability of MHSA but they can only accomplish their mission when voluntarily provided county-level data by the Department of Health Care Services (DHCS), who struggle to gather and compile data from the counties. Additionally, when data is reported, it does not consistently measure the same indicators across the state. While *Promises* touches on the root cause of limited aggregated data – "input" challenges, bureaucracy, and an overburdened DHCS, among the most notable – the fact still remains that no checks and balances are in place to ensure timely and accurate reporting of MHSA impact. Recommendation 4 from *Promises* – to implement a statewide mental health data collection system and report regularly to the legislature and the public - is still critically relevant and yet remains unmet.

Furthermore, we would argue that an equally important role for the OAC is to expand their scope from financial reporting to community and systems level programmatic outcome evaluation. Until recently, the OAC's efforts have focused on individual program assessment. However, with new leadership, there appears to be a concerted effort to restore confidence in the MHSA by demonstrating statewide impact. We encourage the Commission to focus on outcomes evaluation to determine the efficacy of MHSA-

funded programs and encourage coordinating with state counterparts to develop a robust reporting system. This endeavor requires collaboration from all parties, including DHCS, the counties, and the OAC, and so we encourage the Little Hoover Commission to provide additional recommendations to further the progress of collaboration.

3) MHSA lacks meaningful opportunities to share best practices and test innovations across the state.
The vision of the MHSA when passed by voters in 2004 was to ensure transformational change of the behavioral health delivery system; a system in which CCHCs play a vital role in both providing direct services and coordinating care among the continuum of physical, psycho-social, and supportive services. *Promises* outlines how amplified local control over MHSA strategic plan approval, while within the boundaries of the initial design of Proposition 63, also has negative effects like challenging statewide data transparency and providing no venue for disseminating best practices. We agree with this assessment and we believe the lack of outcome data prohibits systematic evaluation, thus quashing public support for MHSA-funded services and preventing growth in efficacy of programs to treat the mentally ill in California. CPCA encourages the Little Hoover Commission to further inquire about the status of producing innovative best practices models of care and update the public with their findings.

Creating the MHSA was a huge step forward for California voters and an indication that the mental health of our fellow Californians is an important priority for our state. MHSA has enormous potential to improve our historically fractured mental health system. It deserves the attention and scrutiny it receives. To that point, CPCA appreciates the high quality of investigative reporting and analysis found in *Promises Yet to Keep*. The report is a goldmine of context and history of the act and provides an extensive set of spot-on recommendations for MHSA's future. This follow up hearing further heightens our confidence in the Little Hoover Commission's commitment to ensuring opportunities like MHSA are regularly and thoughtfully examined on behalf of curious state constituents. Thank you for your effort and the opportunity to comment.

Respectfully,

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President and CEO
California Primary Care Association

cc:
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